STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0003	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5- 412 Initial comments An unannounced Licensure Biennial survey was conducted August 28, 2014 by two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted the survey. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 06/20/2013)	T 000		
T 140	12 VAC 5-412-210 B Patients' rights B. The facility shall establish and maintain complaint handling procedures which specify the: 1. System for logging receipt, investigation and resolution of complaints; and 2. Format of the written record of the findings of each complaint investigated. This RULE: is not met as evidenced by: Based on record review and interview the facility staff failed to ensure their system of complaint handling procedures was followed for 4 of 4 complaints reviewed. The findings include: On 8/28/14 at approximately 10:20 A.M. the complaint log was reviewed. There were complaints dated 9/13/12, 3/26/13, 4/4/13 and 7/3/14. Complaint dated 9/13/12 did not contain an investigation or outcome; Complaint dated 3/26/13 did not have an investigation or outcome; Complaint dated 4/4/13 did not have a documented outcome and Complaint dated 7/3/14 did not have a documented outcome. The Staff member #1 was interviewed on 8/28/14 at approximately 4 P.M. and stated, "I do not have	T 140	T140 The administrator has reviewed the policy to ensure in the future that all complaint forms are completed in its entirety. The Compliance offices will review complaints during the quarterly inspection.	9/4/14

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T 140	Continued From Page 1 the documentation."	T 140		
T 155	12 VAC 5-412-210 E Patients' rights E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the: 1. Facility contact person; and 2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place. This RULE: is not met as evidenced by: Based on document review and interview the facility staff failed to ensure each patient was provided the name, mailing address and phone number of OLC (Office of Licensure and Certification). The findings included: Upon entering the facility on 8/28/14 a copy of the patient rights was posted on the wall. The posting did not include the address of the OLC. As each patient was checked in they were handed a clipboard with the same information as posted on the wall taped to the front of the clipboard. Staff Member #1 stated, "I didn't realize we didn't have the address on the information."	T 155	T 155 The sheet has been corrected to include address. Staff has been trained to provide each patient with this information. Administrator will ensure that these forms are continually provided to all patients.	9/4/14
T 160	12 VAC 5-412-210 F Patients' rights The facility shall maintain documentation of all complaints received and the status of each	T 160		

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T 160	Continued From Page 2 complaint from the date of receipt through its final resolution. Records shall be maintained for no less than three years. This RULE: is not met as evidenced by: Based on record review and interview the facility staff failed to ensure their system of complaint handling procedures was followed for 4 of 4 complaints reviewed. The findings include: On 8/28/14 at approximately 10:20 A.M. the complaint log was reviewed. There were complaints dated 9/13/12, 3/26/13, 4/4/13 and 7/3/14. Complaint dated 9/13/12 did not contain an investigation or outcome; Complaint dated 3/26/13 did not have an investigation or outcome; Complaint dated 4/4/13 did not have a documented outcome and Complaint dated 7/3/14 did not have a documented outcome. The Staff member #1 was interviewed on 8/28/14 at approximately 4 P.M. and stated, "I do not have the documentation."	T 160	T 160 The administrator has reviewed the policy to ensure in the future that all Compliant forms are completed in its entirety. The Compliance officer will review Complaints during the quarterly inspection.	9/04/14
T 165	12 VAC 5-412-220 A Infection prevention A. The abortion facility shall have an infection prevention plan that encompasses the entire facility and all services provided, and which is consistent with the provisions of the current edition of "Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care", published by the U.S. Centers for Disease Control and Prevention. An individual with training and expertise in infection prevention shall participate in the development of infection prevention policies and procedures and shall	T 165		

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T 165	Continued From Page 3	T 165	T165	10/10/14

review them to assure they comply with applicable regulations and standards.
1. The process for development, implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented.
2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing.
3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review.

This RULE: is not met as evidenced by:
Based on observations and interviews the facility staff failed to ensure they followed their infection control plan. During the initial tour of the facility and during observations of patient care items were identified that did not appear to have been cleaned: exam rooms and tables were dirty and stained, sonogram machines were dirty, had hair in the crevices, 3 of 3 pillow cases on the pillows ready for use were stained with make-up, the air condition vents/intake vents were dusty, stirrups had peeling paint, one of 4 cots used for recovery had tears, corrugated boxes were stored in patient care areas, three counter tops had missing or broken pieces. Blood pressure cuffs were not cleaned between each patient use. And they failed to date when items were opened.

The findings include:

On 8/28/14 during the initial tour and during patient care with Staff Member #1 the following observations were noted;
1. Sonogram room #1 had a dirty exam table, and

① Cleaning schedule has been Adjusted to address and provide time for cleaning of the Sonogram room and All items in it.

② Company has been contacted for cot vinyl repair. Pillow covers are changed every day After clinic. Corregated boxes have been removed from cabinet.

⑥ Stir-ups on procedure table have been repaired 9/24/14

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T 165	Continued From Page 4 the sonogram machine had hair and some type of sticky substance in the holding areas and crevices of the machine. 2. Recovery room one of four cots had tears. Staff member #1 was asked if the cots were ready for patient use and she stated, "Yes". Three of the cots had pillows on them. Three of three pillow covers had make-up stains on them. 3. Sonogram room #2 had a dirty exam table and had corrugated boxes in the shelves, the Formica counter top was missing the end caps exposing the wood 4. Lab counter had missing and peeling Formica counter top exposing the wood 5. Dirty utility room counter top had missing end caps on the Formica counter leaving exposed wood. 6. The stirrups of the procedure table had peeling paint 7. The Omni cleaner and Steam Autoclave cleaner were not dated as to when they were opened and accessed. During the patient observations from approximately 12:00 to 2:00 P.M. in the recovery area blood pressure cuffs were used on patients. The cuffs were not cleaned between each patient use.	T 165	T 165 (1) Staff reminded to date opened items. Staff has been trained for cleaning AS An infection control measure And Advised to Alert Administrator in case of Any repairs needed. Administrator will monitor need for repairs And open item dates. Compliance Officer will Also conduct quarterly inspections.	10-10-14
T 335	2 VAC 5-412-300 E Quality assurance E. Results of the quality improvement program shall be reported to the licensee at least annually and shall include the deficiencies identified and recommendations for corrections and improvements. The report shall be acted upon by the governing body and the facility. All corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to	T 335	T335 Administrator and compliance Officer will provide written reports to governing body. Governing body will return formal plan of Areas that need improvement. Policy has been revised to Reflect this.	9/25/14

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T 335	Continued From Page 5 the licensee by the quality improvement committee. This RULE: is not met as evidenced by: Based on document review and interview the facility staff failed to ensure the quality improvement program reported to the licensee at least annually deficiencies identified, recommendations for corrections and improvements. The findings included: On 8/28/14 the quality improvement program and the information forwarded to the governing body was reviewed. There was no evidence information collected, problems identified or corrective actions or recommendations were forwarded to the governing body to act on. The information revealed data had been collected, improvements recommended but no evidence the governing body was made aware of the information. There was no evidence of a formalized plan demonstrating an assessment had been made of areas that may need improvement for the the current 12 months. On 8/28/14 at approximately 1:30 P.M. the quality improvement program was reviewed with Staff Member #2. Staff Member #2 stated, "You are correct, I never sent a report to the governing body. We did find some issues to work on. We did not complete a formalized plan. I can see the benefit of that now."	T 335		
T 340	12 VAC 5-412-310 Medical records An accurate and complete clinical record or chart shall be maintained on each patient. The record	T 340	T-340 Chart reviews will be done on every Chart. Nurse will review charts as pts are seen. Chart completion audits	9/4/14

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T 340	Continued From Page 6 or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, but not limited to the following: 1. Patient identification; 2. Admitting information, including a patient history and physical examination; 3. Signed consent; 4. Confirmation of pregnancy; and 5. Procedure report to include: a. Physician orders; b. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays; c. Anesthesia record; d. Operative record; e. Surgical medication and medical treatments; f. Recovery room notes; g. Physician and nurses' progress notes, h. Condition at time of discharge, i. Patient instructions, preoperative and postoperative; and j. Names of referral physicians or agencies. This RULE: is not met as evidenced by: Based on document review and interview the facility staff failed to ensure the medical record for 2 of 9 records (Record #6 and 7) reviewed were complete and accurate. The findings include: On 8/28/14 at approximately 1:15 P.M. records were reviewed and the following was noted: Record #6 the physician failed to a time when the operative report was signed and failed to indicate a time of discharge. Record #7 the physician failed to indicate the time on the operative report and failed to provide an order for discharge to recovery.	T 340	T340 Will be conducted on every Chart by Administrator. Administrator will monitor to ensure continual proper documentation. Physician has been reminded of proper documentation requirements.	9-4-14

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T 340	Continued From Page 7 Staff Member #2 stated, "Documentation is something we are trying to work on."	T 340		
T 375	12 VAC 5-412-360 A Maintenance A. The facility's structure, its component parts, and all equipment such as elevators, heating, cooling, ventilation and emergency lighting, shall be all be kept in good repair and operating condition. Areas used by patients shall be maintained in good repair and kept free of hazards. All wooden surfaces shall be sealed with non-lead-based paint, lacquer, varnish, or shellac that will allow sanitization. This RULE: is not met as evidenced by: Based on observation and interview the facility failed to provide patients with a means of calling for assistance from the bathroom used by the patients after a procedure. The findings included: The facility was toured on August 28, 2014 at approximately 9:30 A.M. with Staff Member #1. No call light or means of calling for assistance from the facility's staff was found in the patient bathroom used by patients who have had procedures. This bathroom is located directly across from the recovery room area and is used by patients in the recovery room. Staff Member#1 stated, "Well I am right there and pointed to the counter in the recovery area. And the people who are doing the cleaning of the equipment and in this area (Staff Member #1 pointed to an open area between the procedure room and the soiled and clean rooms)."	T 375	T375 If the nurse has to step away from recovery area, support staff has been trained and instructed on their expected roles and duties to step in and assist with patient care. Administrator will continue to monitor the need to address staffing patterns. Call bell has been installed in patient bathroom and the patient recovery area.	

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T 375	Continued From Page 8 At approximately 1:30 P.M. during the observations of patients in the recovery room one patient complained of "feeling like I am going to throw up". The surveyor look for and called by name Staff Member #1. Staff Member #1 was in the bathroom assisting another patient. As Staff Member #1 was exiting the bathroom she was asked if she heard her name being called and she stated, "No".	T 375		

Department: Organization and Management	**Policy Description:** Patients' Rights: Grievance and Complaint Management
Page: 1 of 4	**Replaces Policy Dated:**
Effective Date: 01/12	**Reference Number: 12VAC5-412-200 A-F**
Approved: 01/12	

Scope:	All stakeholders
Purpose:	To establish a process for timely referral, prompt review, investigation and resolution of patient grievances and complaints. **DEFINITIONS:** Complaint is a concern represented by a patient or patient's representative that can be addressed or resolved promptly by staff members who are present at the time of the complaint. "Staff present" includes those individuals close to the complaint situation or who can quickly be at the patient's location to resolve the patient's complaint. Generally, complaints can be resolved timely while the patient is still receiving care at the facility or in response to an issue raised after discharge from the facility. Patient Grievance is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, abuse (verbal, mental, sexual or physical) or neglect, mistreatment, issues related to compliance to regulatory standards, or a Medicare beneficiary billing complaint. A written complaint is always considered a grievance, whether from a patient or their representative. A written complaint also includes those complaints received via electronic mail or facsimile. Regardless of the form in which a complaint is received, whenever a patient or patient's representative requests a response from the facility, the issue is defined as a grievance. Information obtained on patient satisfaction surveys does not usually meet the definition of a grievance. If, however, the patient attaches a written complaint on the survey and requests resolution, then the complaint may meet the definition of a grievance. Written comments should be evaluated to determine if they constitute a complaint or a grievance. **A verbal complaint is a grievance if it cannot be resolved at the time of the complaint by staff present, if it is postponed for later resolution, if it is referred to other staff for later resolution, if it requires investigation, and/or if it requires further actions for resolution.**
Policy:	Each patient and/or the patient's representative will be informed of the grievance process, including whom to contact to file a grievance or complaint. The patient will be informed that a grievance may be directly lodged with the State department of health or in the case of Medicare patients with the Medicare Beneficiary Ombudsman, regardless of whether he/she has first used the

	organization's grievance process. Patient grievances are to be addressed in a timely, reasonable, and consistent manner. Notification to the complainant of the proposed resolution will occur within 30 days from the date of receipt of the complaint. Dedication to providing quality care and service to patients requires an effective mechanism for resolving patient complaints. The goal is to be responsive and foster open communication with patients at all levels within the organization with the objective of resolving complaints expediently through appropriate problem solving actions. Presentation of a grievance or complaint will not compromise a patient's future access to care nor subject the patient to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, or services. **The Governing Body approves and is responsible for the effective operation of the grievance process. The operational responsibility for reviewing and resolving grievances has been delegated to the Administrator. Data collected regarding patient grievances and complaints is incorporated in the quality assessment and performance improvement program with a quarterly report from the Quality Improvement Committee forwarded to the Governing Body for review.** Confidential information will not be shared with the patient's representative or any third party without appropriate written consent given by the patient. The Facility Privacy Officer shall be responsible for overseeing the investigation and resolution of grievances related to the Health Insurance Portability and Accountability Act (HIPAA). The Risk Manager shall be responsible for grievances involving a request or demand for money or threatened litigation.
Procedure:	A. ***Notification of Rights Regarding Complaint/Grievance Resolution*** 1. Each patient and/or patient representative is informed of the rights and responsibilities afforded patients upon entry into the facility, and the process by which they may lodge a complaint. This information includes the designee of the organization, such as the Administrator, and the method of access to the designee to provide immediate assistance as needed. 2. **Each patient receives information on how to lodge a grievance with the state agency upon entry to the facility. The state agency, Virginia Department of Health, 9960 Mayland Drive Suite 401 Richmond, VA 23223 or at (800) 955-1819, phone number, and address are provided in the event that the patient decides not to use the internal grievance process. The website is OLC-compliants@vdh.virginia.gov** B. ***Complaint Resolution Process*** 1. When a patient voices a complaint, the patient will be encouraged to discuss the complaint with the nursing staff and/or their physician. If the complaint is related to a particular department, a representative from that department may be invited to discuss the issue with the patient. The Administrator may be involved as needed to assist with prompt resolution. 2. Every effort will be made to resolve the complaint at the lowest level possible. Each staff member is empowered to respond and resolve promptly any complaint voiced by a patient and/or their representative. The staff member receiving the complaint will notify his/her supervisor when the issue cannot be immediately resolved. At each level of this process, the staff member will listen with concern to the

patient's complaint, consider the circumstances and context of the complaint, assure the patient that their complaint will be investigated and resolved as soon as possible.

3. At any point in the process, the complaint may become a grievance based on aforementioned criteria.

C. ***Grievance Resolution Process***

All grievances must be immediately reported to a person in authority when a facility employee is made aware of the grievance.

1. Grievances may be received written, verbally, via electronic mail or facsimile, or by telephone to any department. Upon receipt of a grievance, the Administrator shall confer with the appropriate personnel to review, investigate and resolve with the patient and/or patient representative within seven days of receipt of the grievance with the exception of complaints regarding situations in which patient safety may have been jeopardized, such as abuse or neglect. These grievances should be reviewed immediately given the seriousness of the allegations and the potential for harm to the patient. Medical staff leadership may be involved as needed to resolve physician delivery of care issues.

2. Occasionally, a grievance is complicated and may require an extensive investigation. If the grievance will not be resolved, or if the investigation is not or will not be completed within seven days, the complainant should be informed that the facility is still working to resolve the grievance and that the facility will follow-up with a written response within 21 days.

3. Regardless of the nature of the grievance, the substance of each grievance must be addressed while identifying, investigating, and resolving any deeper, systemic problems indicated by the grievance.

4. In resolution of the grievance, a written notice of the decision must be provided to the complainant that contains the name of the facility contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance investigation, and the date of completion.

5. The written notice must be communicated appropriately to the patient or the patient's representative in a language and manner the patient or the patient's representative understands. When a patient communicates a grievance via email, the response may be provided via email. However, the response must contain the aforementioned elements.

6. At the discretion of the person conducting the investigation, other mechanisms may be utilized to resolve a grievance. For example, conducting a meeting with the complainant may be very effective. However, in all cases a written notice of response with the aforementioned elements must be provided to each patient's grievance.

7. A grievance is considered resolved when the patient and/or patient representative is satisfied with the actions taken on their behalf. There may be situations where the organization has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the actions taken by the organization. In these situations, the Quality Improvement Committee may consider the

grievance closed. However, the organization must maintain documented evidence of compliance with all regulatory requirements.

8. Substantiated allegations of abuse, neglect, or other reportable events will be reported to state or local authorities

D. *Tracking, Trending, and Analysis of Data*

1. A grievance/complaint log will be maintained by the Administrator or designated staff member. The documentation in the log will include date of complaint/grievance, location, summary of issue, how the issue was addressed, date resolved and response to complainant, and the individual responding to the grievance.

2. Documentation of the resolution process will include:

- Name of person representing complaint/grievance and how to contact
- Patient name
- Nature of complaint/grievance
- Date of service
- Pertinent investigational information
- Resolution/follow-up including written response for grievances
- Signature of person addressing complaint/grievance

3. **The above documentation will be maintained by the Administrator or forwarded to the designated staff member. Data will be aggregated, analyzed and reported to the Quality Committee and the Governing Body on a quarterly basis. Based on the QA/PI priorities of the Facility, the Governing Body shall give consideration to requiring the reporting of the following types of data analysis:**

- Reporting of individual cases deemed to be a serious grievance, as defined by the Facility (e.g., potential for causing harm, serious breach of policy, etc.), and any root cause analysis that might have been done in response, if necessary;
- **Total of all complaints/grievances, with analysis of nature/type of problem, frequency of each type, trends by seriousness of problem type, department(s) involved, type of staff involved (e.g., nursing, ancillary, physicians), type of patients involved (i.e. surgical, endoscopy, pain management),**

Peninsula Medical Center for Women
10758A Jefferson Avenue
Newport News, Virginia 23601
(757) 599-6389 – phone (757) 599-0347

Patient Complaint

Date: _____ Time: _____

Name of Patient: _____

Nature of Complaint: _____

Brief description of what happened:

_____

_____

_____

_____

Date and Time of Occurrence:

_____

Contact telephone # for problem resolution: _____

Employee taking report: _____

Complaint reported to: _____

Date: _____ Time: _____

(office use below this line)

Date and time complaint received: _____

Complaint reviewed: YES NO
Employees interviewed: YES NO
Patient interviewed: YES NO
If yes, when_____ By Phone In person
Investigation completed: YES NO
Outcome of Investigation:

_____

_____

_____

Person completing investigation: _____
Date: _____ Time:_____
Was the patient satisfied with the outcome?: _____
What can be done to avoid similar complaints?:

_____

Richmond Medical Center for Women
Peninsula Medical Center for Women
Charlottesville Medical Center for Women
Roanoke Medical Center for Women

Clinical Policies and Procedures Manual

Department: Quality Assurance	**Policy Description:** Quality Management, Quality Assurance and Process Improvement, QAPI
Page: 1 of 2	**Replaces Policy Dated:** 4/1/12; 6/5/12 (300 A, B, C, D, E)
Effective Date: 7/15/13	**Reference Number:** **12VAC5-412-210** A, B, C, D, E
Approved:	

Scope:	All facility personnel
Purpose:	To establish a QAPI program to achieve optimal care for the consumer as well as provide for patient and employee safety.
Policy:	QAPI is a program which allows both administrative personnel and staff to identify real or potential problems, document findings, and use methodology to improve processes to improve outcomes in various areas as noted below.
Procedure:	A. QAPI for the facility serves as an ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided, including services provided under contract or agreement. The program includes process design, data collection/analysis, assessment and improvement and evaluation. The findings are used to correct identified problems and revise policies and practices. B. To ensure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences the following shall be evaluated: 1. Staffing patterns and performance, done annually and as needed. 2. Supervision appropriate to the level of service, done annually and with position vacancies. 3. Patient records; with one record checked weekly by site administrator; and full audit of all records current with procedure day every other month; and as determined by chart errors found through audits. 4. Patient satisfaction; through patient satisfaction queries in a format ensuring privacy of responses. 5. Complaint resolution; through audits for trends. See also policy on patient rights (12VAC5-412-200, B, C, & D.) 6. Infections, complications and other adverse events; audits done and occurrences sent to Regional Director for trending. 7. Staff concerns regarding patient care. 8. Periodic safety checks on all equipment C. The quality improvement (QI) committee is responsible for the oversight and supervision of the program and shall consist of: 1. A physician 2. A non-physician health care practitioner 3. A member of the administrative staff

	4. An individual with demonstrated ability to represent the rights and concerns of patients. This may be a member of the facility's staff. 5. There may be coordination between the Regional Director's multiple sites of responsibility to provide a range of insight helpful to the improvement process. D. When problems are identified measures shall be implemented to resolve the problems and concerns that have been identified. E. Results of the quality improvement program will be reported to the licensee at least annually and shall include the deficiencies identified and recommendations for corrections and improvements. The report shall be acted upon by the governing body and the facility. All corrections actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee. F. Quarterly inspections assessing facility quality audits on documentation, infection prevention and other subjects as the need arises, and including a tour of the facility for compliance of State Regulations are to be done by the Compliance Officer who shall review findings with the Administrator of the facility for quality improvement and corrections. The quarterly inspections will be sent to the Governing Body and the Administrator of the facility will advise the Governing Body within fifteen working days of corrections made, and if ongoing monitoring is needed.
Reference:	12 VAC5-412-210-A, B, C, D, E; & 12 VAC5-412-200 B, C, D

W.K.G. & J, Incorporated
118 North Boulevard
Richmond, Virginia 23220

The Governing Authority for Richmond Medical Center for Women, Charlottesville Medical Center for Women, Peninsula Medical Center for Women, and Roanoke Medical Center for Women

September 23, 2014

Response to CO report on QA for Peninsula 1-27-14

Concur with Action plan to continue monitoring infections and other complications.
Continue with patient satisfaction surveys. Complaints seem to be related to mis-communication of expectations with patients. Staff must listen to patients to ensure that staff and patients understand each other. Have concerns that staff gives information but doesn't do enough listening.
Conduct chart audits to detect problem areas in documentation.
Consider sending letters to pt's PMD with their permission. May increase goodwill with PMDs as well as increase awareness of complications.

Peninsula Medical Center for Women
10758A Jefferson Avenue Newport News, Virginia 23601
(757) 599-6389 – phone (757) 599-0347– fax

Peninsula Medical Center for Women's team of staff and physicians is dedicated to providing quality, personalized healthcare to the members of our community.
Our plan of care encompasses all aspects of your surgical experience. Your pre-operative, intra-operative and optimal recovery needs will be met to the best of our best ability while you visit our center.

At the Peninsula Medical Center for Women your rights include the following:

- Safe considerate and respectful care
- Privacy, personal and informational
- Be kept well-informed and participate in your healthcare decisions
- Know the names and roles of Care-givers
- Be fully informed of risks, benefits, expected outcomes and alternative treatments for scheduled procedures
- Consent to or refuse treatment without being subjected to discrimination or reprisal
- An advance directive, such as a living will, health care proxy, or surrogate decision maker
- Confidentiality of your medical record
- Review your medical record
- Awareness of the potential ownership interest in the facility by your physician
- Consultation with a specialist
- Participate in your pain management treatment to enhance your recovery
- Consent to or decline to take part in research affecting your care
- Know about center rules that will affect you, your treatment and your payments
- Access protective services
- Access to an interpreter
- Accommodation of special needs for handicapped or sensory impaired persons
- Explanation of the need for your transfer to another facility

To voice concerns or grievances regarding care received please contact:
Administrator @ (757) 599-6389 or
Virginia Department of Health (804) 367-2104 or Toll-Free at 1 (800) 955-1819
9960 Mayland Drive, Suite 401
Henrico, Virginia 23223

You have the responsibility to:

- Provide information about your present and past health history and medications
- Ask questions when you do not understand information or instructions
- Keep your health care providers informed of your level of discomfort in a timely manner to maximize the effectiveness of your pain management treatment plan
- Be considerate of the rights of other patients, center staff and center rules and regulations
- Inform us if you have an advance directive and provide a copy to the center
- Comply with the treatment plan and instructions for follow-up care
- Assure financial obligations for healthcare services received are promptly met
- Inform center personnel if any special needs or accommodations are required

W.K.G. & J, Incorporated
118 North Boulevard
Richmond, Virginia 23220

The Governing Authority for Richmond Medical Center for Women, Charlottesville Medical Center for Women, Peninsula Medical Center for Women, and Roanoke Medical Center for Women

September 23, 2014

To: Monica Hunter, RN, MSN, Administrator
Lin Rasmussen, BSN RNC-OB, Compliance Officer

From: Jill Abbey, President

Re: Assessment of areas needing improvement

I have reviewed reports made by the CO and the report made by the inspectors with the Office of Licensure and Certification. In addition, I was present for the exit interview on the day of the inspection. (August 28, 2014)

Areas needing improvement

1. Cleanliness

I have had conversations with the administrator to emphasize the need for routine cleaning and terminal cleaning. She has increased the floor cleaning provided by outside contractor. We have discussed having time set aside when the staff may concentrate their efforts on cleaning. I have discussed with her that cleanliness is a matter of infection control.

2. Documentation

Documentation has been an issue at all of our sites. As the CO has pointed out, Peninsula has had the best performance but still needs improvement. The administrator will pay attention to missing pieces of documentation as we are seeing patients but also will conduct regular chart audits for completion.

3. Complaint Management

Policies have been revised to indicate that all complaints must be addressed within 30 days of the complaint. The CO will monitor complaint reports as part of the quarterly inspections that she conducts to ensure that reports are complete and timely.

Action

The diligence of the CO has been appreciated in detecting problem areas. The administrator must complete the next step in carrying out the correction of problems. The inspector graciously called deficiencies "opportunities for improvement"; we can all benefit from that attitude.

1. The CO will continue with her quarterly inspections.
2. She will submit her findings to the administrator and the Governing Authority.
3. The administrator will respond to the CO's report within 15 days.
4. The Governing Authority will review the reports and provide a plan for improvement.
5. Staff will do terminal cleaning after each procedure day. Then they will use Friday mornings for an overall cleaning of the building.
6. Chart audits will be completed and the results provided to the CO
7. The CO will monitor any complaints and evaluate the handling of the complete to ensure that there is a documented outcome for each one.